

Domestic Violence

A woman is beaten every 8 – 15 seconds in the U.S.

16% go on to abuse alcohol

33% have clinical depression

10% abuse or overuse drugs

26% of suicide attempts in women are battered women

80% of victims report at least once to a doctor

Health professionals identify 1 in 20

40% seek medical attention on more than 5 occasions

50% of injuries seen in women in the ER are from abuse

Battered women are given psychiatric and pain medicines 3 times more often than are non-battered women.

Battering in Pregnancy

Battered women are 3 times more likely to be injured when pregnant

Average 4.5 Beatings per pregnancy

Battering in pregnancy is more common than gestation DM and placenta previa.

Domestic Violence

Includes emotional and physical abuse between partners, child abuse and elder abuse.

Estimates of frequency: 20-30% of US women have been abused by an intimate partner during adulthood. Occurs for men, but much more common for women. Similar rates in gay/lesbian relationships.

Medical sequelae: Can include PTSD, depression, anxiety, broken bones, seizures, chronic pain, substance abuse, somatization, as well as worsening of chronic illnesses and death.

Why doctors don't ask: Lack of TIME, lack of resources, fear of offending patient, belief that patient lacks initiative, over-identification with victim, sense of powerlessness to make a difference, belief that patients won't admit to abuse anyway, etc.

Why patients won't admit to abuse: fear, shame, covering for partner (caught in cycle of violence), doesn't acknowledge being a victim, fear they won't be believed, etc.

Screening: Recommended by Family Violence Prevention Fund for all women over age 14 in primary care and ER. Clues to prompt questioning include: delay in seeking care, illogical explanation of injury, multiple somatic complaints, depression/anxiety, pregnancy, substance use, recent dx of HIV, family hx of domestic violence, or presence of overbearing partner.

Cycle of violence: Tension building phase followed by acute battering followed by lull/calm/loving phase followed by increasing tension and possibly worse abuse

Battered Women's Syndrome:

Screening questions: Introduce topic: "Because violence is so common in people's lives, I've begun to ask all my patients about it." Or "I'm concerned that your symptoms may have been caused by someone hurting you."

Assessment questions: "Are you in a relationship with a person who physically hurts or threatens you?" "Did someone cause these injuries? Was it your partner?" "Do you feel controlled or isolated by your partner?" "Do you ever feel afraid of your partner?" "Is it safe for you to go home?" "Has your partner forced you to have sex when you didn't want to?"

Remember that just raising this issue with a patient changes their view, no matter how they respond.

Women are at the most danger when they leave a violent relationship.

The Cycle of Violence
from Lenore Walker, Ph.D. The Battered Woman

Phase One: Tension Building

PERPETRATOR	VICTIM
<ul style="list-style-type: none"> *Anger in low stage *Verbal harassment of victim *Minor battering and humiliating incidents increasing in frequency *Growing fear that victim will leave *Increase in possessiveness, jealousy *Increased surveillance of her activities *Increase in aggressiveness as frustration builds *Increase in stress, anxiety, anger 	<ul style="list-style-type: none"> *Nurturing, compliant, accepting *Does everything she can to "keep peace" *Denial of anger *Justification of perpetrator's behavior *Blames outside stressors *Assumption of responsibility to manage partner's behavior, covering up *Alienation of helpful others, social withdrawal *Increase in stress, anxiety, anger, terror

Phase Two: Acute Battering

PERPETRATOR	VICTIM
<ul style="list-style-type: none"> *Characterized by lack of predictability, lack of control, and destructiveness *Violent discharge of tension, ie. RAGE *"Teach her a lesson" *Justification: blames on partner *Impaired awareness *Emotional exhaustion *Decrease in self-esteem 	<ul style="list-style-type: none"> *Passive acceptance *Learned helplessness: belief that it's futile to try to escape or resist *Distancing, dissociation, disbelief *Minimizing of injuries *Emotional collapse after 1-2 days *Depression *Isolation *Delay in seeking help *Decrease in self-esteem

Phase Three: Calm, Lull, Loving

PERPETRATOR	VICTIM
<ul style="list-style-type: none"> *Loving, contrite, kind *Asks forgiveness *Promises 'never again' *Dependency on partner's acceptance and validation of self *Ambivalence about self 	<ul style="list-style-type: none"> *Complete victimization *Guilt about leaving *Responsibility for partner *Belief in partner; hope partner will change *Feels needed, validated, elevated *Ambivalence about self

At the completion of the cycle, it recurs. Symbiotic bonding is completed, and the partners feel total dependence on each other.

WHAT KIND OF PSYCHOLOGICAL ABUSE HAVE YOU EXPERIENCED IN THIS RELATIONSHIP?

Check off all that apply during this particular relationship. Use the following codes:

1 = has not occurred

2 = threatened

3 = once

4 = two to four times

5 = five or more times, frequently.

PSYCHOLOGICAL TORTURE

Isolation

- ☐ Locked in a house, room or closet
- ☐ Tied up with rope, chains, handcuffs, etc.
- ☐ Forced to live in isolated settings
- ☐ Frequent moves
- ☐ Controlled socialization with family or friends
- ☐ Monitored use of telephone/mail

Degradation

- ☐ To curse, name-call such as stupid, worthless etc
- ☐ To depreciate
- ☐ Public humiliation
- ☐ Private humiliation
- ☐ Denial of power or competency
- ☐ Forced prostitution or sex acts with others
- ☐ Forced pornography
- ☐ Rejection (emotional, intellectual, social, sexual, affectional)

Denial of Reality

- ☐ Denial of power or competency
- ☐ Told or convinced person is mentally ill
- ☐ Lying and manipulating partner
- ☐ "gaslighting" techniques

Induced Debility Producing Physical Distress or Exhaustion

- ☐ Forced to take on role of servant
- ☐ Forced to clean house or work excessively long hours
- ☐ Obsessive needs for cleanliness such as towels placed just right
- ☐ Interference with sleep patterns
- ☐ Interference with eating and nutrition
- ☐ Not allowed personal or rest time

Alcohol or Drug Administration

- ☐ Forced to use alcohol or other drugs
- ☐ Forced to participate in sale/distribution of drugs
- ☐ Induced dependence upon drugs

Monopolizing of Perceptions

- ☐ Pathological jealousy
- ☐ Controlled activities
- ☐ Economic control
- ☐ Checking up on where partner is (surveillance)
- ☐ Forced partner to live up to abuser's expectations
- ☐ Refuse discussions or negotiations

Threats to Kill

- ☐ Threats to kill partner or children
- ☐ Threats to kill others
- ☐ Threats to commit suicide
- ☐ Threats using weapons
- ☐ Sham executions
- ☐ Threats to kidnap or keep children

ARE YOU OR SOMEONE YOU LOVE IN DANGER OF BEING SERIOUSLY INJURED OR KILLED?

It is difficult to know what kind of danger you or someone you love are in when exposed to someone who has previously been abusive. This checklist is sometimes used as a guideline. Each category of behavior is indicative of risk for further abuse. The more that are present in a relationship, the higher risk for the woman or man in the relationship.

Remember, between 40% to 60% of all women who are killed, die at the hands of a former or current partner who abused them. Obviously, that means that the other half were not known to be abuse victims. But, you can prevent unnecessary deaths or serious injuries by taking precautions if some of these factors are present in your relationship or that of someone you love!

Lethality Guide

- ☐ 1. Frequency of man's use of violence is escalating.
- ☐ 2. Severity of man's violence is escalating.
- ☐ 3. Man's threats to kill woman or others.
- ☐ 4. Frequency of intoxication from alcohol and other drug use.
- ☐ 5. Man's threats to harm children.
- ☐ 6. Man's forced or threatened sex acts.
- ☐ 7. Man's or woman's suicide threats or attempts.
- ☐ 8. Weapons kept at home or easily accessible.
- ☐ 9. Psychiatric impairment of man or woman.
- ☐ 10. Proximity of man and woman - how close to where they both work and live.
- ☐ 11. Man's need for control of contact around the children.
- ☐ 12. Current life stresses in man's or woman's lives.
- ☐ 13. Man's previous criminal history.
- ☐ 14. Man's attitudes towards violence.
- ☐ 15. Presence of a new relationship for either man or woman.

These factors are not in a particular order of seriousness but have been found in various empirical studies of escalating domestic violence. They were first published in (Walker, L.E.A. (1994). Survivor Therapy Workbook on Assessment and Intervention. Endolor Publications: Denver, CO.

IS THERE TOO MUCH ABUSE IN YOUR RELATIONSHIP OR IN SOMEONE YOU LOVE'S RELATIONSHIP?

It can be difficult to tell if a relationship has become very abusive especially when it began with a very strong bond of love. Observing behavior rather than just listening to what someone says is the best way to tell if there is too much abuse even if no one has raised a hand to hit, yet.

The following questions have been developed in various battered woman's programs around the world. Try to answer them for your relationship or for someone who you love? If there are more than five categories checked off, or any one of the last five questions, then there is too much abuse in that relationship and steps to change it should be undertaken immediately.

DOES THE PERSON YOU LOVE

1. Have to know where you are all the time?
2. Constantly accuse you of being unfaithful?
3. Discourage your relationships with family and friends?
4. Want you to stop working or attending school?
5. Criticize you for little things?
6. Anger easily especially when drinking or using drugs?
7. Control all the finances and make you account for every penny you spend?
8. Refuse to keep a job and force you to pay all the bills?
9. Humiliate you or insult you in front of others?
10. Destroy your personal property or sentimental things?
11. Demand sex even when you do not want it?
12. Hit, punch, slap, push, pull your hair, shake, kick, twist your arms or legs, bite you or your children?
13. Threaten to hurt you or your children?
14. Threaten to or actually use a weapon against you or your children?
15. Coerce or force you to perform sexual acts you don't want to engage in?

If you check off more than 5 of these items or items #12, 13, 14, or 15, then there is too much violence in your home and you need to do something to help your family survive right now!

Call the national domestic violence hot line at 1-800-333-SAFE right now to find a local battered woman shelter or 1-900-772-3872 for more information from the Family Survival Network.

ARE YOU BEING STALKED?

Here are some common stalking behaviors? We have learned that stalking during a relationship or after it has ended is high risk behavior and if it is occurring to you or to someone you love, safety precautions must be taken. In most states many of these behaviors are also against the anti-stalking laws. Gather evidence and make police reports!

Common Domestic Violence Stalking Acts

- ☐ Mailing cards or other cryptic messages
- ☐ Breaking windows, breaking into or vandalizing partner's home
- ☐ Taking partner's mail
- ☐ Leaving things such as flowers on doorstep or at work
- ☐ Watching partner from a distance
- ☐ Hang up calls on the telephone
- ☐ Following partner with a car
- ☐ Following partner on foot
- ☐ Hiding in bushes or other surveillance of partner's home
- ☐ Surveillance of partner at work
- ☐ Other trespassing
- ☐ Vandalizing partner's property
- ☐ Destroying property to scare or intimidate partner
- ☐ Stealing things from partner
- ☐ Breaking into partner's house or car
- ☐ Filing numerous pleadings in court cases
- ☐ Filing for custody of children regardless of their needs
- ☐ Not respecting visitation limitations
- ☐ Harassing telephone calls or notes
- ☐ Violation of restraining orders

WHAT KINDS OF SEXUAL ABUSE HAVE YOU BEEN SUBJECTED TO?

Check off all that apply during this particular relationship. Use the following codes:

1 = has not occurred

2 = threatened

3 = once

4 = two to four times

5 = five or more times, frequently.

Sexual Abuse/Violence

Unwanted Sexual Advances

Unwanted Sexual Gestures

Taking Advantage of a Power Relationship

Unwanted Direct Sexual Requests

Hostile Atmosphere Towards Women

Sexual Touching of Clothing and Body Areas

Unwanted or Rough Touching of Specific Genital Areas

Any Sexual Touching of Minors

Forcing Vaginal Intercourse with or without Orgasm

Forcing Oral Sex

Forcing Anal Sex

Inserting Objects into Genitals

Forcing Masturbation

Rough Sex Causing Genital Bruises or Mutilation

Forcing Prostitution

Forcing Pornography

Forcing Sex with Other People

Forcing Viewing Others Having Sex

Sexual Contact when STD's Are Known or Suspected

Sexual Contact when HIV Positive

Other Sexual Abuse

WHAT KIND OF PHYSICAL VIOLENCE IS USED IN THIS RELATIONSHIP?

Check off all that apply during this particular relationship. Use the following codes:

1 = has not occurred

2 = threatened

3= once

4 = two to four times

5 = five or more times, frequently.

Physical Violence

Pushing

Shoving

Slapping (front and backhand)

Hitting

Grabbing

Spitting

Punching with Fist

Pulling Hair

Pinching

Biting

Clawing or Scratching

Kicking (shoes on or off)

Kneeing

Head Shaking

Head Banging

Choking

Throwing Against Wall

Throwing Across Room

Throwing on Floor or Ground

Throwing Against Other Objects

Pinning Against Wall or on Ground

Sitting or Standing On

Hanging by Neck, Arms, or Feet

Wrestling

Twisting Arms, Legs, Fingers

Handcuffing

Tying with a Rope or other Material

Throwing Objects

Hitting with Objects

Attempting to Drown

Burning

Forcing to Eat Non-Edible or Poisonous Substances

Threatening/Using a Knife

Threatening/Using a Gun

Threatening/Using an Automobile Recklessly

Threatening/Using Other Lethal Weapon

Communicating With Special Populations

Communicating With Patients About Intimate Partner Violence: Screening and Interviewing Approaches

Colleen T. Fogarty, MD; Sandra Burge, PhD; Elizabeth C. McCord, MS, MD

Intimate partner violence is a major public health concern; it contributes to poor physical and mental health in affected individuals, primarily women. Due to documented poor detection rates of intimate partner violence by physicians, the medical community has focused increasing attention on the successful identification of victims in all medical contexts. Family medicine educators need to be aware of the current status of knowledge about intimate partner violence and convey this to students and residents. In this article, we review the literature on screening tools to identify victims of partner violence, discuss the pitfalls of relying on screening tools, review barriers to identification of partner violence from clinician and patient perspectives, and recommend a patient-centered method for conversing with patients about intimate partner violence.

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Intimate partner violence is a major public health concern; it contributes to poor physical and mental health in affected individuals, primarily women.¹⁻⁴ Data from the National Crime Victimization Survey estimates that in 1998, 1 million individuals experienced violent crime at the hands of current or former partners; 85% of the victims were women.⁵ Partner violence is common across the life span, affecting adolescents in dating relationships,⁶ adult women, pregnant women,⁷ and elderly women.⁸ Domestic violence costs the US health care system \$44 million in medical costs, 40,000 physician visits, and 100,000 days in hospital stays annually.⁶

Researchers have documented high numbers of victims of intimate partner violence in clinical outpatient settings, ranging from a prevalence of 8%–22% for current abuse and 28%–36% for lifetime abuse,⁹⁻¹³ where physicians, immersed in the competing demands of everyday practice, have overlooked them.¹⁴⁻¹⁸

Researchers identify victims of violence using survey methods that are impractical for use in a busy clinic.¹⁹⁻²² The length of these scales precludes use as

clinical screening instruments, though they have been useful in research studies to define and measure the prevalence and dynamics of abusive relationships.

The medical community has urged physicians to incorporate screening into practice.^{1,23-25} In response, medical educators have developed guidelines for teaching trainees about intimate partner violence^{1,26,27} and have developed resources for faculty development.²⁸ The medical community has developed screening strategies, modeled after research tools, to increase identification of victims of violence.^{10,29-39} Although, to date, no controlled outcome studies have been done that examine screening or detection of intimate partner violence, the practice is widely encouraged⁴⁰ because asking screening questions is noninvasive, safe, and may improve outcome.⁴¹

In this paper, we review the literature on screening tools for intimate partner violence, discuss barriers to identification of victims from clinician and patient perspectives, and propose patient-centered strategies for communicating with patients about domestic violence.

Methods

We performed a MEDLINE search (1966 through June 2001) for articles evaluating screening tools using the MeSH terms “domestic violence,” “spouse abuse,” “battered women,” and the keyword “partner violence,” and found 3,132 articles. We combined this set with

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the terms "mass screening" ("exploded"), "risk assessment," or "data collection" (exploded). The combined set yielded 833 articles. We reviewed titles and abstracts and selected 140 articles whose titles and keywords were related to screening for and detection of domestic violence by medical professionals. Of these, 13 articles evaluated specific screening tools for domestic violence.^{7,10,30-33,37-39,42-45} Review of the bibliographies identified one other study for review.⁴⁶ In reviewing these articles, we identified instruments with documentation of reliability or validity, preferably both.

Results

We found five instruments that had documentation of validity and reliability,^{30,31,37,38,43,46} two instruments that had validity testing only,^{30,32} one instrument that had reliability testing only,³⁹ and two that had neither reliability or validity testing^{10,44} but demonstrated an increased detection rate of domestic violence using the screening tools with patients. Four of the original 13 papers we identified^{7,33,42,45} used the Abuse Assessment Screen (AAS)⁴⁶ reviewed below. Table 1 provides the complete set of questions for each reviewed instrument. Table 2 summarizes psychometric properties of each.

WAST

The Woman Abuse Screening Tool (WAST)³⁰ was developed for use by family physicians to identify female patients experiencing abuse in their current relationships. An initial eight-question tool was administered to a group of women from a battered women's shelter and a group of women with no known history of abuse. After initial analysis, one question was eliminated due to low correlation. Both the seven- and eight-item WAST were found to significantly correlate with the Abuse Risk Inventory (ARI);⁴⁷ correlation coefficients ranged from .80 to .85. The WAST was also able to reliably differentiate the abused from the nonabused women, both on individual items and with overall scores.³⁰ This study also showed that abused women felt less comfortable with the questions than the nonabused women did.

A shorter version of the WAST was created for initial screening using the two questions with the highest comfort scores (questions 1 and 2).³⁰ The WAST-Short correlated with the entire WAST but did not have separate reliability testing. These two questions were scored using 1 to score the most extreme response and 0 for the other responses, for a range of 0-2. Using a cut-off score of 1, this instrument identified 100% of the nonabused women and 91.7% of the abused women. Follow-up evaluation of the WAST used in family practices in London, Ontario, found a correlation coefficient of .75 of the WAST with the ARI, and physicians and patients were both comfortable with the screening instrument.³¹

WEB

The Women's Experience With Battering Scale (WEB) was originally developed based on qualitative work with abused women to measure not just physical markers of battering but also the women's psychological experiences of an abusive relationship.⁴⁸ This self-administered 10-item scale was validated in a cross-sectional study of family practice patients⁴³ with an alpha of .95. The measure demonstrated good agreement with the Index of Spouse Abuse (ISA) physical violence subscale. The range of scores on the WEB is 10-60; scores ≥ 20 indicate battering.⁴³

HITS

HITS is a screening tool designed for use in outpatient clinical settings. This four-question screening tool is based on an acronym for Hurt, Insult, Threaten, and Scream.³⁸ HITS was evaluated with female family practice patients and women residing in crisis shelters or presenting to the emergency department. Responses between two groups were compared, and a significant difference in mean scores was found. Reliability was .80. Validity was demonstrated by good correlation with the Conflict Tactics Scale (CTS). The cut score was set at 10.5, which would correctly classify 96% of victims and 91% of office participants.³⁸

AAS

The Abuse Assessment Screen (AAS) was developed as a five-question screen for abuse during pregnancy.^{7,46,49-51} Question 3 may be omitted when interviewing nonpregnant women. The AAS is not designed to be used with a total score; therefore, each item was compared to the CTS, the ISA, and the Danger Assessment (DA) Scale⁵² for validation. Reliability was assessed by the test-retest method; 48 women yielded an 83% agreement between the two measures. The investigators used a hypothesis testing approach to validity testing by comparing average scores on the DA and/or specific subscales of the CTS and ISA between abused and nonabused women identified by the AAS. They found a significant difference on all the scores except for the Conflict Tactics Scale reasoning subscale.⁴⁶

Dartmouth COOP Charts

The Dartmouth COOP Charts are picture and word questions developed for general health screening.⁵³ The Relationship Chart was evaluated as an intimate partner violence screen for primary care offices.³⁷ The Relationship Chart was validated by asking a group of 51 women in domestic abuse support groups and a control group of randomly selected patients in obstetrics and gynecology practices to complete the chart and the Abuse Behavior Inventory (ABI).⁵⁴ Test-retest correlation was .60 at 10 days; 88.4% of the responses on the 5-point scale stayed the same or shifted by only 1 point.

Table 1

Screening Instruments for Intimate Partner Violence

Screening Tool Woman Abuse Screening Tool (WAST)	<p><i>Items</i></p> <ol style="list-style-type: none"> 1. In general, how would you describe your relationship? A lot of tension, some tension, or no tension 2. Do you and your partner work out arguments with . . . ? Great difficulty, some difficulty, no difficulty 3. Do arguments ever result in you feeling down or bad about yourself? 4. Do arguments ever result in hitting, kicking, or pushing? 5. Do you ever feel frightened by what your partner says or does? 6. Has your partner ever abused you physically? 7. Has your partner ever abused you emotionally? 8. Has your partner ever abused you sexually?
WAST- Short	<ol style="list-style-type: none"> 1. In general, how would you describe your relationship? A lot of tension, some tension, or no tension 2. Do you and your partner work out arguments with . . . ? Great difficulty, some difficulty, no difficulty
Women's Experience With Battering (WEB)	<ol style="list-style-type: none"> 1. He makes me feel unsafe even in my own home. 2. I feel ashamed of the things he does to me. 3. I try not to rock the boat because I am afraid of what he might do. 4. I feel like I am programmed to react a certain way to him. 5. I feel like he keeps me prisoner. 6. He makes me feel like I have no control over my life, no power, no protection. 7. I hide the truth from others because I am afraid not to. 8. I feel owned and controlled by him. 9. He can scare me without laying a hand on me. 10. He has a look that goes straight through me and terrifies me.
HITS	<p>How often does your partner:</p> <ol style="list-style-type: none"> 1. Physically Hurt you 2. Insult you? 3. Threaten you with harm? 4. Scream or curse at you?
Abuse Assessment Screen (AAS)	<ol style="list-style-type: none"> 1. Have you <i>ever</i> been emotionally or physically abused by your partner or someone important to you? 2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? 3. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? 4. Within the last year, has anyone forced you to have sexual activities? 5. Are you afraid of your partner or anyone you listed above?
Relationship Chart	<ol style="list-style-type: none"> 1. During the past 4 weeks, how often have problems in your household led to: insulting or swearing? yelling? threatening? hitting or pushing?
Partner Violence Screen (PVS)	<ol style="list-style-type: none"> 1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom? 2. Do you feel safe in your current relationship? 3. Is there a partner from a previous relationship who is making you feel unsafe now?
Partner Abuse Interview (PAI)	<p>Has your partner . . . yes/no injury codes</p> <ol style="list-style-type: none"> 1. Thrown something at you 2. Pushed, grabbed, or shoved you 3. Slapped you 4. Kicked, bit, hit you with a fist 5. Hit or tried to hit you with an object 6. Beat you up 7. Threatened you with a gun or knife 8. Used a gun or knife 9. Forced you to have sex when you didn't want to 10. Other

Scoring strategies for this instrument are not provided, but it is noted that as the reported frequency of abuse increases on the Likert scale, this correlates with increasing scores on the ABI. Other Dartmouth COOP charts use level 4 and 5 of the response category to indicate significant functional limitation.³⁷

PVS

The Partner Violence Screen (PVS)³² was developed for use in the Emergency Department. Validity analyzed against the CTS^{19,20} and the ISA.²² An affirmative answer to any one of the three questions was considered to be a positive result.

Table 2

Evaluation of Intimate Partner Violence Screening Tools

Screening Tool	Number of Items	Setting	Number	Reliability	Validity
WAST	8	FP outpatient	307	$\alpha=.75$	Correlated to ARI, $r=.69$
WAST	7	Nonmedical	24 shelter, 24 nonclinical	$\alpha=.95$	Correlated to ARI, $r=.96$
WAST-Short	2	FP outpatient	307	Not tested	Correlated to WAST Sensitivity=91.7%; specificity=100%
WEB	10	FP outpatient	1,152	$\alpha=.95$	Correlated to ISA-P, $r=.67$, $\kappa=.60$
HITS	4	FP outpatient	160 FP patients 99 IPV victims	$\alpha=.80$	Correlated to CTS, $r=.81$ to $.85$ Sensitivity=96%, specificity=91%
AAS	4-5	ED	416 women with vaginal bleeding	Test-retest, 83%-100% agreement	Correlated to Danger Assessment, CTS, and ISA subscales; $P\leq.001$
Relationship Chart	1	OB-GYN outpatient	48 controls, 51 victims	Test-retest, $r=.60$	Correlated to ABI, $P=.001$
PVS	3	ED	322	Not tested	Compared to CTS and ISA Sensitivity=64.5%-71.4% Specificity=80.3%-88.7%
PAI ³⁹	11	FP outpatient	90	$\kappa=.77$ to 1.00 , $\alpha=.82$	Not tested

AAS—Abuse Assessment Screen; ABI—Abuse Behavior Inventory; ARI—Abuse Risk Inventory; CTS—Conflict Tactics Scale; ED—emergency department; FP—family practice; HITS—four-question screening tool based on Hurt, Insult, Threaten, and Scream; ISA—Index of Spouse Abuse; PAI—Partner Abuse Inventory; WAST—Woman Abuse Screening Tool; WEB—Women's Experience With Battering Scale

PAI

The Partner Abuse Inventory (PAI) is an 11-item interview modified from the CTS.³⁹ The physical violence items were rated on a 4-point scale, and the fear item was scored on a 3-point scale. The inter-rater reliability was measured at a kappa of .77-1, and the Cronbach's alpha for the instrument was .82. No specific validity testing was done in this study.³⁹

Discussion

Our review of the literature on screening instruments for domestic violence yielded several screening instruments with demonstrated reliability and validity. The WAST, WAST-Short, HITS, and the Dartmouth COOP Relationship Chart were developed for family practice settings. The WAST-Short has the advantage of using only two items (Table 1) and demonstrated both clinician and patient comfort in research and practice settings. We recommend this tool as a useful entry point to querying patients about violence. The HITS has the potential advantage of a mnemonic device, analogous to the CAGE instrument for alcohol screening,^{55,56} however, no one has demonstrated patient comfort with this instrument. The Relationship Chart has the appeal of being a single item, with a pictorial format, which may

be useful for practices that use routine patient-administered databases but may be less practical for clinician-initiated questioning. The five-item AAS, the 10-item WEB, and the 11-item PAI may prove too long to use in routine screening.

The PVS did not provide reliability testing; further, the sensitivity (64%-71%) and specificity (80.3%-88.7%) are lower than that for the WAST-Short. The brevity of the scale and the question about safety are useful, but we do not think this has significant advantages over the other tools.

We recommend using these screening tools in routine practice. However, unlike a biochemical screening test, the effectiveness of these screening tools relies critically on the clinician-patient relationship. One study of a written self-report screen⁵⁷ identified 7% of Planned Parenthood patients as abused. When a nurse interviewer asked the same questions, the prevalence of patients identified as abused was nearly 30%. This study provides highly suggestive evidence that the interpersonal nature of the questioning has much more to do with disclosure than the questions themselves. Barriers to mutual understanding and disclosure exist on both sides of the clinician-patient relationship.

The Physician's Perspective

A landmark qualitative study done in 1990⁵⁸ found that physicians' unwillingness to ask questions about intimate partner violence stemmed largely from fear of "opening Pandora's box" or opening a "can of worms." Subsequent studies have identified barriers for physicians' screening for intimate partner violence in three general spheres: psychological issues, attitudes, and health systems barriers^{16,59-61} (Table 3). Physician management in cases of female partner violence relates to whether the woman acknowledges or reveals the abuse.⁶²

Women understand and recognize abuse and actually consider more behaviors abusive than those typically cited in the literature.⁶³ This supports the concept that women in abusive situations recognize abusive behaviors and refutes the perception of nearly 75% of clinicians in one study, who stated, "What I view as abuse, my patient accepts as normal."⁶⁰

The Patient's Perspective

Clinical anecdotal experience with patients,^{64,65} survey data,⁶⁶ and qualitative findings^{67,70} suggest that a battered woman's ability to answer any screening tool candidly is a complex process. Factors involved in this process include the woman's recognition of a problem, her willingness to trust her clinician with this information, and her perception of the clinician's openness to hearing her story with compassion and without judgement. The cycle of abuse often leaves a woman feeling disempowered and lacking credibility, both of which may leave her vulnerable to nonrecognition of a problem, fear of disclosure, and fear of partner retaliation or escalated violence.

Compared to women who have not been abused, battered women feel less satisfied with medical encounters,^{71,72} perceive poorer communication with the physician, and are less likely to feel respected and accepted during the medical encounter.^{71,72} Barriers to patient disclosure of intimate partner violence include psychological factors, social factors, and health system barriers^{67,68} (Table 3).

Abused women have made suggestions for health care providers to assist women with disclosure. These women recommend a good patient-provider relationship composed of trust, compassion, support, and confidentiality. They encourage direct questioning by the physician for

routine screening for abuse and when the patient has obvious injury or subtle signs of abuse. Women they would be more likely to disclose abusive actions if they perceived the clinician to be caring and compassionate, easy to talk with, and protective, and if they were asked in a private manner and offered follow-up care. Women endorsed being given emotional support, being asked for any questions or concerns, and being examined in a dignified and sensitive manner.^{66,68,70}

These studies of battered women thus strongly support the importance of both screening for intimate partner violence and doing so in the context of excellent clinical communication and a positive clinician-patient relationship.

Educational Issues

Medical educators have a responsibility to teach trainees the skills to screen for and diagnose intimate partner violence while recognizing that a significant portion of learners and teachers in the medical community have personal histories of family violence.^{77,78} Well-designed studies have demonstrated that trainees increase their feelings of competence and rate of diagnosis after exposure to educational programs about domestic violence.^{81,82} However, family practice residencies on average provide only 4-5 hours training annually about detection of intimate partner violence, typically in the form of didactic lectures.²⁷ Therefore, having a screening tool or programmed set of questions is useful for trainees who are learning to ask about sensitive issues like domestic violence.

Table 3

Barriers to Disclosure of Intimate Partner Violence

PHYSICIAN FACTORS^{16,58-60}

Psychological factors

Fear of offending patient
Powerlessness
Loss of control
Over-identification (with victim)

Attitudes

Beliefs

Patients lack initiative
Patients won't admit to abuse

Prejudices

Class elitism
Racial prejudice
Patients are "noncompliant"

Health system barriers

Time limitations

PATIENT FACTORS^{67,71,72,84}

Psychological factors

Fear (partner retaliation or escalated violence)
Shame
Embarrassment

Social factors

Obligation to family/partner

Health system barriers

Disinterested/unsympathetic clinicians
Not being believed by clinician
Poor communication with clinician
Not feeling respected or accepted
Lack of clinician time
Long waiting times
Health care costs
Possible legal involvement

Conclusions

This paper has focused on increasing physicians' skill at identifying intimate partner violence, using both a screening approach and patient-centered strategies. Future research needs to address several related issues of relevance to clinical family medicine. First, we need to understand the full spectrum of intimate partner violence. Second, we need to develop effective treatment and prevention strategies, with special attention toward practices that care for both partners in a violent couple.⁸³ Third, we must examine outcomes related to improved physician detection and management of intimate partner violence. Finally, we need to develop effective strategies for screening men for partner violence. Ultimately, our work should lead to strategies that prevent violence and promote peace in families.

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TEN STRENGTHS OF TRAUMA BONDS

1. WHEN THE TRAUMA CYCLES ARE REPEATED SO INTENSITY AND FORGIVENESS BECOME REINFORCING
2. WHEN THE VICTIM BELIEVES IN THEIR UNIQUENESS
3. WHEN THE VICTIM MISTAKES INTENSITY FOR INTIMACY
4. WHEN THE TRAUMA ENDURES OVER TIME
5. WHEN THERE ARE INCREASING AMOUNTS OF FEAR
6. WHEN THE FEAR INDUCED NEUROCHEMICAL REACTIONS OCCUR EARLIER IN LIFE AND EFFECT THE ORGANIC DEVELOPMENT OF THE BRAIN
7. WHEN THE TRAUMA IS PRECEDED BY EARLIER VICTIMIZATION
8. WHEN THE VICTIM IS SURROUNDED BY REACTIVITY AND EXTREME RESPONSES
9. WHEN THE BETRAYAL OF POWER RELATIONSHIPS IS GREATER
10. WHEN THE BETRAYAL OF TRUSTED RELATIONSHIPS IS GREATER

